STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	C 04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR FOULK MANOR NORTH LLC	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 11, 2011 through April 13, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The census on the first day of the survey was ten (10). The survey sample totaled five (5) residents (R1 through R5), all of which were active records. There were no discharges within the past year to do a closed record review. Additionally, there were five (5) subsampled residents (SS6 through SS10).	F 000	Responses to the cited deficiencies do not constitute an admission of agreement by Foulk Manor North of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.	
F 287 SS=F	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 287		5/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Virginia C. Gray	Executive Director	April 28, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 287	Continued From page 1 A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment. Annual assessment. Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the offsite survey prep and staff interview, it was determined that the facility failed to electronically transmit MDS data for 10 out of 10 Medicaid residents (R1-R5 and SS6-SS10). Although MDS assessments were completed for these residents, the facility failed to complete the necessary steps to electronically transmit any 3.0 MDS assessments since October 2010. Findings include: During the survey prep prior to entering the facility, it was noted in the State system that there were no 3.0 MDS assessments that had been	F 287	A. On April 11, 2011, the Facility immediately notified the Corporate MDS Specialist, who, in turn, electronically transmitted all MDS 3.0 assessments since October 2010. B. All residents have the potential to be affected by the transmittal of the MDS 3.0 assessments. C. The Assistant Director of Nursing/MDS Coordinator has been properly trained on the complete process for transmitting MDS 3.0 assessments. Any changes in the transmittal process will be communicated timely to the MDS Coordinator to ensure compliance. D. MDS submissions will be reviewed and validation reports will be reviewed monthly by the NHA/designee to ensure compliance times three (3) months. Findings will be reviewed in with corrective action as warranted. Completion Date: May 15, 2011 and Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 287	Continued From page 2 transmitted for the facility. During the survey, however, record reviews indicated that 3.0 MDS assessments were completed. On 4/12/11, E3 (Assistant Director of Nursing/MDS Coordinator) and E4 (Corporate Nurse) were interviewed. E3 stated that she began working in the facility in July 2010 using 2.0 MDS assessments. When 3.0 MDS assessments started in October 2010, E3 stopped receiving validation reports when transmitting assessments, however, she thought it was part of the 3.0 change. E3 additionally stated that she tried to electronically submit the 3.0 MDS assessments the same way she did the 2.0 MDS assessments and she did not realize that an extra step was required to transmit the 3.0 assessments. E4 stated that the facility was unaware that they were not successfully transmitting 3.0 MDS assessments until the surveyor brought it to their attention on 4/11/11. E4 stated that she contacted the corporate MDS specialist on 4/11/11 after becoming aware of the issue and the specialist consequently transmitted all of the 3.0 MDS assessments for the 10 residents on 4/11/11. E3 and E4 confirmed that since the 3.0 MDS assessments were transmitted the evening before, error messages were coming in which were now being corrected.	F 287		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 3 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: 1. On 4/11/11 at 8:45 AM, observation of the vegetable prep sink in the kitchen revealed that the drain pipe was directly piped through the wall and did not have the required air gap per the Delaware 2011 food code. Interview with E5 (Food Service Assistant Director/Chef) on 4/11/11 revealed that meat and vegetables were no longer handled in the same prep sink. An interview with E6 (Maintenance Director) on 4/12/11 revealed that an air gap was missing from the vegetable prep sink. 2. On 4/11/11 at 11:30 AM, a dietary staff member (E7) was observed prepping sandwiches in the kitchen, opening jars, opening refrigerator doors, and touching ready-to-eat food such as pickles without washing her hands. E7 kept the same pair of contaminated gloves on and failed to replace the gloves as necessary and failed to wash her hands to remove the potential for contamination. 3. On 4/11/11 at approximately 9 AM, the following were observed in the kitchen with dirt,	F 371	**A.** **(1)** Upon notification by the surveyor, on April 11, 2011, the Facility immediately replaced the existing drain pipe with the air gap drain. **(2)** The Facility immediately discarded the ready-to-eat pickles and contaminated gloves. E7 was provided education of proper hand washing and handling of food. **(3a, b, c)** The Facility cleaned the meat slicer, stainless steel vegetable sink as well as beneath the sink and the identified soiled frying pans. **(3d, e)** The dishwasher and Garland convection oven will be cleaned and maintained on a regular schedule. **(3f)** The clean plates storage area will be properly cleaned and covered and the storage area will be free of debris. **(3g)** The grease trap will be cleaned and the three (3) identified condiments and walls of the dishwasher were wiped clean and free of spillage and stains and drippings. **(3h, i)** On April 11, 2011, the Facility cleaned the three (3) condiment bottles.	5/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 4 grease deposits, food debris, or stains: a. The deli/meat slicer located in the kitchen prep area had food debris encrusted below the cutting area surface of the cutting blade on 4/11/11 and 4/13/11. b. The stainless steel vegetable sink was observed dirty on 4/11/11. Debris was also observed under the vegetable sink. c. Two (2) out of seven (7) frying pans stored on the ready to use rack were observed with grease on the non-food contact areas of the pans. d. On 4/13/11 at approximately 8 AM, the top of the dishwasher was observed with debris. e. The Garland convention oven top front doors had yellow spills and splatters or stains on the exterior surfaces. f. Debris was observed inside the cooking areas of two (2) ovens where clean plates were stored and the storage rack containing clean plates near the dishwasher was uncovered. g. Debris on top of the grease trap under the three compartment sink was observed. h. Three bottles of condiments stored on the dry food storage area rack were observed with spills or drippings on the exterior surfaces. i. The walls under the dishwasher and the 3 -compartment sink were observed with black stains. E5 confirmed these findings.	F 371	**B.** All residents have the potential to be affected by soiled kitchen equipment, cooking surfaces and food contamination. The Director of Food and Dining Services and/or designee, will in-service all dietary staff on the Facility's policy on Handwashing Techniques, Kitchen, Sanitation and Cleaning Schedule and Equipment Cleaning Procedures. **C.** The Director of Food and Dining and/or designee, will implement a daily cleaning schedule to maintain the cleanliness of kitchen equipment, walls and kitchen surfaces. **D.** The Director of Food and Dining Services and/or designee, will conduct weekly rounds and monthly audits times three (3) months to ensure the daily cleaning schedule and proper handling of food is being maintained. The Executive Chef and/or designee, will conduct daily rounds to ensure staff are discarding gloves and washing hands between use. The Director of Food and Dining will review checklists and discuss all findings with the NHA with corrective actions as warranted. Completion Date: May 15, 2011 and Ongoing	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Revised state report 4/29/11 **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual survey and complaint visit was conducted at this facility from March 11, 2011 through March 13, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was forty-four (44). The survey sample totaled fourteen (14) residents, eight (8) open records, one (1) closed record and five (5) sub-sampled residents.	Responses to the cited deficiencies do not constitute an admission of agreement by Foulk Manor North of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.
3201	**Regulations for Skilled and Intermediate Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out**	

Provider's Signature Gina A. Jay NHA Title EXECUTIVE DIRECTOR Date May 5, 2011

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **F 387 §483.40(c) Frequency of Physician Visits** **Frequency of Physician Visits** **(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.** **(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.** Based on record review and interview it was determined that the physician failed to visit on a regular basis one (S13) out of 14 sampled residents. Findings include: Review of S13's record revealed that from 8/26/10 through 3/14 /11 (6 1/2 months) E12 (S13's physician) failed to come to the facility and evaluate S13. There was documentation indicating that staff were faxing information to E12 and calling him concerning S13's care needs including Coumadin orders. Findings were confirmed with E2 (DON) on 4/12/11. E2 stated that she called E12 several times to come in and see S13 to no avail. E2 stated that	A. A letter will be sent to the physician with regard to the need for timely visits. The Medical Director will also communicate with this physician of the need for compliance. B. The medical records of all residents currently being seen by this physician were audited on April 13, 2011 to ensure compliance with visits. No further issues were identified. C. The unit manager will maintain a physician visits schedule to ensure compliance. Physicians will be notified in the ten (10) day window of the sixty (60) day visit if their residents have not been seen. D. Random chart audits will be completed by the DON/designee, monthly, times three (3) months, to ensure timely physician visits have been documented as per regulations. Findings will be reported to the NHA with corrective action as warranted. Completion Date: May 11, 2011

NAME OF FACILITY: Foulk Manor North DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	the medical director then contacted E12 instructing him to come visit S13. Consequently, E12 evaluated S13 on 3/14/11.	
3201.6.3.2	**Treatments and medications ordered by a physician shall be administered using professionally accepted techniques in accordance with 24 Delaware Code, Chapter 19.** Based on observation, record review, and interview it was determined that the facility failed to follow the plan of care for the use of a "Sit to Stand" lift while being transferred for one (S11) out of 14 sampled residents. Findings include: S11 was admitted with diagnoses that included dementia, diabetes mellitus type II, and renal insufficiency. Review of S11's "Resident/Care giver Information Form" (communication form documenting how staff are to care for a resident) dated 12/4/10 documented S11 was to be transferred with a "Sit to Stand" (mechanical lift used to transfer a resident). Review of S11's physician order, dated 12/21/10, stated, "Stand-up Lift" (also known as a Sit to Stand lift). Review of the April 2011 Treatment Record for S11 documented "Stand-up lift for all transfer with 2-person assist."	A. S11 remains in the facility and is currently being transferred with two (2) person assistance as per care plan. E10 and E11 will be provided education and corrective action on proper transferring of resident with the use of mechanical lifts. B. All residents requiring a mechanical lift for transfers have the potential to be affected. C. All direct care staff will be provided re-education for proper transfer techniques with use of the mechanical lift. D. Weekly observations will be conducted, at random, by the DON/designee during care rounds to ensure compliance. Findings will be reviewed by the NHA with corrective action as warranted. Completion Date: May 11, 2011

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Review of S11's nurses notes revealed on 4/7/11 and 4/8/11 that S11 was to be transferred by 2 people with a mechanical lift (Stand up Lift). On 4/11/11 at 7:25 AM, E10 (LPN) and E11 (CNA) were observed transferring S11 from the bed to the wheelchair without using the sit to stand. They wheeled S11 into the bathroom and transferred S11 from the wheelchair onto the commode without using the sit to stand lift. At approximately 7:35 AM after E11 left the bathroom, E10 transferred S11 from the commode to the wheelchair without a second person to assist her with the transfer and she did not use the stand up lift. On 4/12/11, the observations were reviewed and confirmed by E10 who stated that she knew S11 was a 2-person transfer with a stand up lift. E10 stated it was faster to transfer S11 without the stand up lift.	
3201.6.7	**Pharmacy Services**	
3201.6.7.1	**Each nursing facility shall have a consultant pharmacist who shall be responsible for the general supervision of the nursing facility's pharmaceutical services.** Based on record review, review of the narcotic count sheet, Xanax medication card, and interview it was determined that the pharmacy failed to provide the proper dose of Xanax for one (S11) out	

NAME OF FACILITY: Foulk Manor North DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	of 14 sampled residents as ordered by the physician. Findings include: R11 had a physician order, dated 8/17/10, for Xanax .50 mg take one tablet by mouth every 6 hours as needed for agitation. The order was faxed along with the C2 form (controlled substance form) to the pharmacy. The facility received a medication punch card with the Xanax .50 mg tablets. S11 had a physician order, dated 10/2/10, for "Xanax 0.25 mg by mouth daily at 2 pm and every 6 hours as needed for agitation....D/C previous Xanax 0.5 mg by mouth order". There was evidence in the clinical record that the facility faxed the order to the pharmacy and a C2 form was completed. Review of R11's monthly physician order sheets for November 2010 through March 2011 revealed that nursing staff wrote in the order for Xanax 0.25 mg and sent a copy back to the pharmacy. However, the pharmacy did not fill the order and Xanax 0.25 mg was not available for R11. On 4/12/11 at 11:55 AM, a telephone interview was conducted with E8 (PharmD) who stated that the order was not filled because the facility failed to send a C2 form with the order. E8 further stated that when the pharmacy does not have the C2 form they call the	A. R11 remains at the Facility and a C2 form was sent to the pharmacy. Resident is currently receiving Xanax 0.25mg as per physician orders with the correct dose and labeling of the medication punch card. B. All residents requiring a C2 form for medication have the potential to be affected. C. Pharmacy and nursing will meet to establish a protocol and to ensure proper communication has occurred and C2's are timely received. D. All new orders that require C2's will be checked by the supervisor to ensure receipt of medication. The DON/designee will weekly review the pharmacy manifest sheets to ensure receipt of C2 medications ordered. Findings will be reviewed with the NHA with corrective as warranted. Completion Date: May 11, 2011

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	facility to let someone know. There was no evidence that the pharmacy contacted the facility to let them know they did not receive the C2 form, even after the order was written onto physician order sheets and copies were sent to the pharmacy from November 2010 through March 2011. On 4/13/11 at 8:30 AM, an interview was conducted with E1 (Administrator) who confirmed there was a communication problem between the pharmacy company and the facility. E1 stated that she was going to contact the pharmacy so they could work together to put a process in place to prevent further communication problems and to ensure that medications were available to residents as ordered.	
3201.6.8	**Medications**	
3201.6.8.10	**Any medications removed but not administered to the resident shall not be returned to the original container. In circumstances such as refusal of drugs by the resident, the drugs shall be discarded and the refusal recorded on the resident's Medication Administration Record (MAR). If the medication is a controlled substance, the signature of the administering nurse is required on the record of the controlled substance.** Based on record review, review of the narcotic count sheet, Xanax medication	

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	card, and interview it was determined that the facility failed to destroy narcotics that were not administered to one (S11) out of 14 sampled residents. Findings include: Review of the facility's policy and procedure revealed "Controlled Substances Management 10. If a dose is removed from the container for administration, but refused by the resident or not given for any reason, it must be immediately destroyed in the presence of two licensed nurses. The disposal must be documented on the declining inventory record on the line representing the dose. This documentation will include the signature of both individuals witnessing the destruction and the date and time it occurred." Review of S11's record revealed a physician order dated 8/17/10 for Xanax .50 mg take one tablet by mouth every 6 hours as needed for agitation. The order was faxed along with the C2 form (controlled substance form) to the pharmacy. The facility received a medication punch card with the Xanax .50 mg tablets. On 10/2/10 S11 had a physician order for "Xanax 0.25 mg by mouth daily at 2 pm and every 6 hours as needed for agitation....D/C previous Xanax 0.5 mg by mouth order". There was evidence in the clinical record that the facility faxed the order to the pharmacy and a C2 form was completed.	A. S11 remains in the Facility and had no negative adverse effect. E10 was provided education on proper destruction of narcotics. B. All residents receiving narcotic have the potential of being affected. C. All licensed staff will be educated on the proper destruction of narcotics and the Facility's Medication Management Guidelines Policy. D. The DON/designee will conduct a random audit of the medication cart's narcotic box/book, weekly times one (1) month and then monthly, times two (2) to ensure compliance. Findings will be reported to the NHA and corrective action will be completed as warranted. Completion Date: May 11, 2011

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Review of R11's Xanax medication card in the locked medication cart revealed that the facility did not receive Xanax .25mg tablets from the pharmacy. However, Xanax .50 mg tablets were still available in the locked cart for S11. Review of S11's narcotic count sheet for Xanax .50 mg. revealed that nursing staff documented on the narcotic count sheet that they were breaking the .50 mg Xanax scored tablets in half. The nurses were administering a 1/2 tablet (equal to .25 mg) to S11, then replacing the other half back in the pocket and taping it closed instead of wasting it with another nurse. The nurses documented on the narcotic count sheet there was a beginning count of 8 1/2 tablets with the count decreasing by a ½ tablet with each administration. On 4/13/11 at 9:15 AM, E10 (LPN) confirmed that she was the first nurse to break the Xanax .50 mg tablet in half. E10 administered S11 a ½ tablet, put the other ½ tablet back in the whole, and taped it closed. E10 denied calling the pharmacy to ensure that the proper dose of Xanax was received for S11.	
3201.7.5	**Kitchen and Food Storage Areas.** **Facilities shall comply with the 2011 Delaware Food Code.** **2-301.14 When to Wash.**	

NAME OF FACILITY: Foulk Manor North DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling service animals or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled equipment or utensils; P 45 (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands. Cross refer to the CMS 2567-L survey report date completed 4/13/11, F371, Example #2. **4-602.11 Equipment Food-Contact**	**A.** **(1)** Upon notification by the surveyor, on April 11, 2011, the Facility immediately replaced the existing drain pipe with the air gap drain. **(2)** The Facility immediately discarded the ready-to-eat pickles and contaminated gloves. E7 was provided education of proper hand washing and handling of food. **(3a, b, c)** The Facility cleaned the meat slicer, stainless steel vegetable sink as well as beneath the sink and the identified soiled frying pans. **(3d, e)** The dishwasher and Garland convection oven will be cleaned and maintained on a regular schedule. **(3f)** The clean plates storage area will be properly cleaned and covered and the storage area will be free of debris. **(3g)** The grease trap will be cleaned and the three (3) identified condiments and walls of the dishwasher were wiped clean and free of spillage and stains and drippings. **(3h, i)** On April 11, 2011, the Facility cleaned the three (3) condiment bottles.

NAME OF FACILITY: Foulk Manor North

DATE SURVEY COMPLETED: April 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Surfaces and Utensils. **(A) Equipment food-contact surfaces and utensils shall be cleaned:** **(1) Except as specified in ¶ (B) of this section, before each use with a different type of raw animal food such as beef, fish, lamb, pork, or poultry;** **(2) Each time there is a change from working with raw foods to working with ready-to-eat foods:** **(3) Between uses with raw fruits and vegetables and with potentially hazardous food (time/temperature control for safety food);** **(4) Before using or storing a food temperature measuring device; and** **(5) At any time during the operation when contamination may have occurred.** Cross refer to the CMS 2567-L survey report date completed 4/13/11, F371, Example #3a, 3b, 3f. **4-602.13 Nonfood-Contact Surfaces.** **Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.** Cross refer to the CMS 2567-L survey report date completed 4/13/11, F371, Example #3c, 3d, 3e, 3f, 3h. **5-402.11 Backflow Prevention.**	**B.** All residents have the potential to be affected by soiled kitchen equipment, cooking surfaces and food contamination. The Director of Food and Dining Services and/or designee, will in-service all dietary staff on the Facility's policy on Handwashing Techniques, Kitchen, Sanitation and Cleaning Schedule and Equipment Cleaning Procedures. **C.** The Director of Food and Dining and/or designee, will implement a daily cleaning schedule to maintain the cleanliness of kitchen equipment, walls and kitchen surfaces. **D.** The Director of Food and Dining Services and/or designee, will conduct weekly rounds and monthly audits times three (3) months to ensure the daily cleaning schedule and proper handling of food is being maintained. The Executive Chef and/or designee, will conduct daily rounds to ensure staff are discarding gloves and washing hands between use. The Director of Food and Dining will review checklists and discuss all findings with the NHA with corrective actions as warranted. Completion Date: May 15, 2011 and Ongoing

NAME OF FACILITY: Foulk Manor North

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	(A) Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. Cross refer to the CMS 2567-L survey report date completed 4/13/11, F371, Example #1. **6-501.12 Cleaning, Frequency and Restrictions.** **(A) Physical facilities shall be cleaned as often as necessary to keep them clean.** Cross refer to the CMS 2567-L survey report date completed 4/13/11, F371, Example #3g, 3h, 3i.	